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Issue date: 09May2002

Case No.: **2001-LHC-0522**

OWCP No.: **06-112219**

In the matter of

JOANNE C. MOORE,
Claimant,
v.

BILLETING, NAS CECIL FIELD, FLORIDA
c/o CONTRACT CLAIMS SERVICES,
Employer/Carrier,
and

DIRECTOR, OFFICE OF WORKERS' COMPENSATION PROGRAMS,
Party-In-Interest.

DECISION AND ORDER GRANTING BENEFITS

This proceeding arises from a claim filed under the provisions of the Longshore and Harbor Workers' Compensation Act, as amended, 33 U.S.C. 901 et. seq.

A formal hearing was held in Jacksonville, Florida on JULY 12, 2001 at which time all parties were afforded full opportunity to present evidence and argument as provided in the Act and the applicable regulations.

The findings and conclusions which follow are based upon a complete review of the entire record in light of the arguments of the parties, applicable statutory provisions, regulations and pertinent precedent.

STIPULATIONS[1]

The Claimant and the Employer have stipulated to the following:

1. That the parties are subject to the jurisdiction of the Longshore and Harbor Workers' Compensation Act;

2. An Employer/Employee relationship existed at all relevant times;

3. That the applicable average weekly wage is $277.08 per week;

4. That the Claimant has been paid compensation as reflected on the Form LS-208, Exhibit E-11.

[Tr. at 5:4-10.]

Preliminary Matters

Mrs. Moore seeks temporary total disability rather than permanent total disability. Therefore, the Employer has reported that the time is not ripe to apply for Section 8(f) relief.

Issues

1. Whether or not Claimant suffered compensable injuries on September 23, 1987.

2. Claimant's entitlement to temporary total disability from July 14, 1994 through July 9, 1996, and from and after May 26, 1998.

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[1] *The following abbreviations will be used as citations to the record:*

JS - *Joint stipulations;*
TR - *Transcript of the Hearing;*
CX - *Claimant'S Exhibits; and*
EX - *Employer's Exhibits.*

Contentions

The Claimant states that she was injured in 1979

when she was struck in the head by a large piece of frozen meat, injuring her low back. She in fact was knocked unconscious and was taken to the dispensary on the base and ultimately sent to the hospital by the employer.

On the day in question in September, 1987, the accounting office was moving from one location to another and all of the stored files needed to be moved. While carrying out sixty to seventy-five pound boxes of files, which was an extremely unusual activity for her, in that she was strictly an office worker, she re-injured her back. Her condition did not improve and she ultimately went to the hospital on October 31, 1987 for examination and treatment. She was sent from there to treat with Dr. Carlos Arce, and finally she was diagnosed with a ruptured disk at L4-5, although in this period in time, she continued to work through the pain.

It was only when the ruptured disk was finally diagnosed that the employer stepped up to the plate and filled out workers′ compensation papers so that she could have the surgery. The surgery was done on November 27, 1987. At that time, the Carrier went back and repaid Claimant′s insurance carrier for Dr. Arce’s previous bills, picked up the cost of the surgery, and began paying temporary total disability payments, as required by law and the terms of the insurance policy.

She recovered from the laminectomy in February 1988, and went back to work full-time at her old job. Her ability to work only lasted a short period of time, and by the middle of March of that year her back continued to deteriorate. Repeat myelograms indicated further ruptures at L4 and L5. As of March 12, 1988, Claimant went back out on temporary total disability and remained in that status through July 13, 1994.

In May of 1988, Claimant under went two separate surgeries for the same low back condition, those surgeries did not improve her condition, and a fusion was subsequently performed.

The Claimant contends that at the time of the injury in 1987, she informed a coworker, Helen Deshazo, and her supervisor, Bob Stanus. She informed the Employer that she was going to seek treatment. Her private physician treated her and she later sought care from others. The Employer completed papers in order for her to undergo surgery in late 1987.

The Claimant reports that she has been totally disabled since she last worked in March 1988. Counsel argues that

> this record clearly demonstrates that point has long come and gone and that the Carrier's defense that there was no accident should not and can not be countenanced. Besides from that, it has been demonstrated above that there was in fact an accident and Claimant is entitled to the compensation requested.

The Employer argues that she did not mention an injury to her supervisor in September 1987.

According to the Claimant, she knew that she had injured her back as soon as it occurred [Exhibit E-32 at 26:19-27:21]. Nevertheless, the Claimant did not report the injury. The Claimant went to Dr. Arce, her neurosurgeon, on November 5, 1987 [Exhibit E-14 at 1-2], but she still did not mention the September 23rd injury. Dr. Arce performed surgery on November 27, 1987. The Claimant did not, however, mention the alleged injury until December 7, 1987 — more than two months after the injury supposedly occurred [Exhibit E-3; Exhibit E-39]. All of this is utterly inconsistent with a September 23, 1987 injury.

The Employer states that the claim should be barred as she did not give timely notice as required by Section 12 of the Act. Assuming that Dr. Arce told her of a disc problem on November 5, 1987, no notice was given to the Employer within 30 days.

The Claimant did not notify the Employer of her alleged injury until more than two months later on approximately December 9, 1987 [Exhibit E-39, ¶3]. The Employer was prejudiced because, by then, the Claimant had already had surgery. The Employer could not, therefore, obtain an IME to determine if the Claimant had sustained an injury on September 23, 1987 or whether she was simply experiencing continued symptoms of the 1979 injury [Exhibit E-39, ¶¶ 4-5].

NOTICE OF INJURY OR DEATH

Sec. 12.(a) Notice of an injury or death in respect of which compensation is payable under this Act shall be given within thirty days after the date of such injury or death, or thirty days after the employee or beneficiary is aware, or in the exercise of reasonable diligence or by reason of medical advice should have been aware, of a relationship between the injury or death and the employment, except that in the case of an occupational disease which does not immediately result in a disability or death, such notice shall be given within one year after the employee or claimant becomes aware, or in the exercise of reasonable diligence or by reason of medical advice should have been aware, of the relationship, between the employment, the disease, and the death or disability. Notice shall be given (1) to the deputy commissioner in the compensation district in which the injury or death occurred, and (2) to the employer.

(b) Such notice shall be in writing, shall contain the name and address of the employee and a statement of the time, place, nature, and cause of the injury or death, and shall be signed by the employee or by some person on his behalf, or in case of death, by any person claiming to be entitled to compensation for such death or by a person on his behalf.

(c) Notice shall be given to the deputy commissioner by delivering it to him or sending it by mail addressed to his office, and to the employer by delivering it to him or by sending it by mail addressed to him at his last known place of business.

(d) Failure to give such notice shall not bar any claim under this Act (1) if the employer (or his agent or agents or other responsible official or officials designated by the employer pursuant to subsection (c)) or the carrier had knowledge of the injury or death, (2) the deputy commissioner determines that the employer or carrier has not been prejudiced by failure to give such notice, or (3) if the deputy commissioner excuses such failure on the ground that (i) notice, while not given to a responsible official designated by the employer pursuant to subsection (c) of this section, was given to an official of the employer or the employer's insurance carrier, and that the employer or carrier was not prejudiced due to the failure to provide notice to a responsible official designated by the employer pursuant to subsection (c), or (ii) for some satisfactory reason such notice could not be given; nor unless objection to such failure is raised before the deputy commissioner at the first hearing of a claim for compensation in respect of such injury or death.

TIME FOR FILING OF CLAIMS

Sec. 13.(a) Except as otherwise provided in this section, the right to compensation for disability or death under this Act shall be barred unless a claim therefor is filed within one year after the injury or death. If payment of compensation has been made without an award on account of such injury or death, a claim may be filed within one year after the date of the last payment. Such claim shall be filed with the deputy commissioner in the compensation district in which such injury or death occurred. The time for filing a claim shall not begin to run until the employee or beneficiary is aware, or by the exercise of reasonable diligence should have been aware, of the relationship between the injury or death and the employment.

(b)(1) Notwithstanding the provisions of subdivision (a) failure to file a claim within the period prescribed in such subdivision shall not be a bar to such right unless objection to such failure is made at the first hearing of such claim in which all parties in interest are given reasonable notice and opportunity to be heard.

At the hearing, the Claimant testified that in 1987, she told Deshazo when the injury occurred, and she informed Stanus on the next day. She waited 15 days to see a doctor as she thought that she was going to get better. She saw her private physician on several occasions, and in late October she developed severe leg and back symptoms. There were no injuries between the injury resulting from lifting boxes in September and the episode in October. [Tr. 28].

She went to the hospital and the work up revealed a herniated disc. Private insurance was paying Dr. Arce but when surgery was suggested she went to the "employer" who said

> "Well, I′m going to have the paperwork sent to you and you go ahead and fill out a workers′ comp. You know, and go ahead with the surgery."

She underwent surgery in late November but the paperwork was not completed until January. [Tr 31]. The carrier reimbursed her private insurance company and provided future care.

On October 15, 1987, the Claimant completed a form LS-201 reporting that she stopped working on July 6, [1987] due to a back injury on July 6, 1979. There is a CIGNA date stamp of October 20, 1987 on this form. [EX 1].

On October 15, 1987, the Employer completed an Employer's first report of injury on form LS-202. This indicated that the injury was on July 6, 1979 and that the Claimant continued to have problems with her back. There is a CIGNA date stamp of October 20, 1987 on this form. [EX 2].

A form Ls-202, completed on December 9, 1987 reported that the Claimant was injured on September 23, 1987, last worked on October 6, 1987 and underwent surgery on November 27, 1987. [EX 4].

On December 7, 1987, the Claimant filed a LS-201 reporting an injury to the back while lifting boxes on September 23, 1987. In January 1988, the District Director sent notice of a claim to the Employer and to the Carrier. [EX 3].

In 1996, the Carrier protested payment for treatment in that year. Date of injury was listed as September 23, 1987. Date of Employer's knowledge of the injury was reported to be October 6, 1987. [EX 5]. The carrier repeated the date of first knowledge as October 6, 1987 on many later LS-207 forms. [EX 9, 10, and 12].

Dr. Arce evaluated the Claimant on November 5, 1987. Clinical data indicated that Moore had

> a history of head and neck trauma in 1979 followed by a temporary feeling of weakness and paresthesias in all her extremities. She also had back and left leg pain for which she was treated conservatively with resolution of her symptoms after nine months. Since then she has had back problems on and off that would last a week at the most. However for the last four weeks she has had constant back pain with pain radiating down her right leg, and for the last two weeks she has had numbness in the inner aspect of her right leg. The pain is aggravated by walking, sitting, bending over and is relieved by laying down.
>
> Review of the lumbar sacral spine x-rays brought by the patient from October 1987 showed incomplete fusion of the posterior elements of L5-Sl. Her hip and S1 joint x-rays were normal. A CT scan performed at St. Vincent's, for which only the results are available, was compatible with an L4-5 herniated disc on the right.

Impressions were lumbar radiculopathy, and rule out herniated disc. The physician recommended further testing. Surgery was performed in late November 1987. [EX 14].

The Claimant spoke to a carrier's representative in January 1988. Moore stated that in September 1987

> yearly we have to clean our storeroom, we keep the paperwork for 3 years, sometimes 4 and we had not cleaned the storeroom in over a year and we were in the storeroom and there was a lot of lifting of boxes and, ah, I must have pulled something or I must have done something really bad because it — later on I found out I had ruptured a disc.
>
> when I came back to work I told my boss you know my back was hurting and then it just kept...I didn't fill out an accident report because I had a back injury before and I you know, I had problems before but I did not know that I had really pulled something really severe and so then I went to the doctor. It just kept getting worse and worse and then oh, he treated me, you know, he put me on muscle relaxers and different kinds of medication and ah, I continued to work off and on, you know, going back and forth to the doctor and I just got so that I told him I can't stand anymore — I can hardly get up and go down. You know, you're going to have to do something and he said well, you know, let's just give it a little while longer and take a vacation and he made me stay out of work 3 or 4 days and I had heat, you know, moist heat on my back and all this well, I think it was like the end of October I went to him on a Wednesday and I was crying and I said I can't stand this any more.
>
> I called the physician and he told me to go to the hospital and I went to the hospital and they gave me Demerol and it did not ease the pain so I went back to the doctor on Monday and he said okay I'm going to send you to the hospital and do a CAT scan so he did x—rays before, during the course of this time, and did not find anything. So I went to St. Vincent's Hospital the Tuesday after I talked to the nurse on Friday night and had a CAT scan and that did show something so then he referred me to a neurosurgeon and that's when they put me in the hospital and did a myelogram and they found that my disc was completely retruded(sic). [EX 13].

In June 2001, a declaration was signed

I, Tracie Darling, declare under penalty of perjury the following:

1. I am employed as claims adjuster at Contract Claims Services, Inc., 800 West Airport Freeway, Suite 800, Irving Texas 75062 (“CCSI). CCSI is the third party administrator for the Department of the Navy/MWR’s workers’ compensation program.

2. I am the adjuster assigned to the file for Joanne Moore’s alleged September 1987 back injury (OWCP No. 6-112219).

3. I have reviewed the file for this injury and the documents in Ms. Moore′s claim file indicate that Ms. Moore′s allegation of a September 23, 1987 back injury was not reported to the Navy until approximately December 9, 1987.

4. The Navy was prejudiced by Ms. Moore′s failure to report her September 23, 1987 within 30 days because she had disc surgery in November 1987. By the time she reported her injury, Ms. Moore had already had surgery.

5. The fact that Ms. Moore had already had surgery by the time she reported the injury precluded the Navy from obtaining a medical examination to determine if Ms. Moore′s spinal condition was caused by the alleged September 23, l987 injury or her pre-existing spine condition. [EX 39].

The “1987 injury” occurred some 14 years ago. The exhibits and allegations are muddled as to the date of Claimant’s notice to the Employer. While EX 1 mentions a 1979 injury this notice was given in October 1987, less than a month after the September 1987 injury. EX 2 was filed by the Employer in October, and this also carries the CIGNA (carrier) date stamp.

In view of the above this Administrative Law Judge concludes that timely notice of an injury was given under the criteria in Section 12 of the Act. It is clear that a timely claim was filed under Section 13. It must be noted that the Claimant has indicated that the event in 1987 aggravated the 1979 injury. Whether the damage noted in late 1987 is related to an injury in September of that year or related to aggravation of a previous

work injury results in the same conclusion - payment of benefits - under the Act.

One would question why the employer wasted over ten years to challenge the "work relatedness" of the back surgeries that began in 1987.

Section 20(a) presumption

Section 20(a) of the Act creates a presumption that Claimant's disabling condition is causally related to her employment. 33 U.S.C. § 920(a). In order to invoke the 20(a) presumption, Claimant must prove that she suffered a harm and that conditions existed at work or that an accident occurred at work which could have caused, aggravated or accelerated her condition. Merrill v. Todd Pacific Shipyards Corp., 25 BRBS 140, 144 (1991); Stevens v. Tacoma Boat Building Co., 23 BRBS 191, 193 (1990). Claimant's credible subjective complaints of pain can be sufficient to establish the element of physical harm necessary for a prima facie case and the invocation of the § 20(a) presumption. See Sylvester v. Bethlehem Steel Corp., 14 BRBS 234, 236 (1981), aff'd sub nom. Sylvester v. Director. OWCP, 681 F.2d 359, 14 BRBS (5th Cir. 1982).

The Claimant has reported that she was lifting boxes at work and suffered back pain. A fellow employee was present or was informed of the event on that date. Reportedly, a supervisor was told on the same or next day. [Tr. 26].

In early November 1987, the Claimant saw Dr. Arce as previously noted in this decision, a four week history of constant back pain was reported, and the physician had access to October 1987 reports from St. Vincent's Hospital. Dr. Arce performed surgery in late November 1987. [EX 14].

Clinical data during physical therapy in October 1988 indicated that

> On 9/23/87 patient stated she was lifting a box while doing accounting work for the same company. She felt some low back pain but was reluctant to see a physician. She continued to work on and off until 10/6/87 when she went to St. Vincent's Medical Center because of severe pain. She was under the care of Dr. Smith. OP 11/7/87 the patient stated one night she could not move and had to go to the emergency room. She had right lower extremity weakness and pain and severe low back pain. They treated her with Demerol.

> She was complaining of numbness and weakness in the dorsal foot. Patient was finally referred to Dr. Arce at University Hospital for a CAT scan, myelogram. On 11/22/87 patient was diagnosed with a large HNP at L4-5 and a laminectomy was performed. [EX 14].

The above plus EX 1 support a finding that the Claimant is entitled to the Section 20(a) presumption.

Section 20(a) places the burden on the employer to produce substantial countervailing evidence to rebut the presumption that the injury was caused by the claimant's employment. Cairns v. Matson Terminals, 21 BRBS 252 (1988). Employer must produce facts, not speculation, to overcome the presumption of compensability, and reliance on mere hypothetical probabilities in rejecting a claim is contrary to the presumption created in Section 20 (a). Smith v. Sealand Terminal, 14 BRBS 844 (1982); Dixon v. John J. McMullen & Assocs., 13 BRBS 707 (1981).

Employer attempts to rebut the 20(a) presumption by alleging that Moore did not report the injury to coworkers. Moore mentioned two names but the Employer has not submitted rebuttal statement from these people.

The Employer has focused on inconsistencies in Moore's statements as to whether or not symptoms in late 1987 were related to the 1979 injury or to events in 1987.

At the hearing, the Claimant testified that she worked as a warehouse person until her back injury in 1979. As she had lifting restrictions she was reassigned to office work involving bookkeeping and payroll. She reported injuring her back in 1987 while emptying a warehouse as her office had moved. [Tr. 18-25].

On numerous occasions the Claimant has reported the 1979 injury as being the cause of the 1987 and more recent symptoms.

For discussion purposes, the undersigned will conclude that the Employer's arguments are

> sufficient for rebuttal of the Section 20(a) presumption.
>
> Therefore, this administrative law judge must weigh all the evidence and resolve the case on the record as a whole.

> Under the substantial evidence rule, the administrative law judge's findings, must be based on such relevant evidence as a reasonable mind might accept as adequate to support a conclusion. See DelVecchio v. Bowers, 296 U.S. 280 (1935).

The Claimant has described a situation in which she could have injured her back in 1987 while lifting boxes. The Employer has not rebutted the allegation that Moore informed a coworker and a supervisor at the time of the injury. Reports of treatment from her private treating physician from August 1987 onward are not of record but it is clear that Moore underwent studies in October, shortly after the alleged trauma.

There is no suggestion of a back injury outside of work during the last half of 1987. In addition, the Employer has not submitted a medical report that disputes a relationship of current disability to an alleged injury in September 1987. Moreover, there was an injury in 1979 and one could make the argument that the incident in 1987 aggravated the pre-existing disorder.

The evidence in this case is heavily on the Claimant's side. It is concluded that the Claimant has shown that the September 1987 injury led to numerous lumbar spine surgeries.

Suitable Alternate Employment

The Employer has not suggested that Moore can return to her previous job or to any other work for the Employer.

> Thus, the burden shifts to Employer to show suitable alternate employment. Clophus v. Amoco Prod. Co., 21 BRBS 261 (1988); Nguyen V. Ebbtide Fabricators, 19 BRBS 142 (1986). A failure to prove suitable alternate employment results in a finding of total disability. Manigault v. Stevens Shipping Co., 22 BRBS 332 (1989) (involving injury to a scheduled member); MacDonald v. Trailer Marine Transp. Corp., 18 BRBS 259 (1986), aff'd, No. 86-3444 (11th Cir. 1987) (unpublished).

The Employer argues that

> The Claimant Was Capable Of Working Between July 14, 1994 And July 9, 1996, and from May 1998 onward as Suitable Alternate Employment Was Available If The Claimant Had Looked For A Job.

The Employer states that

> In August 1994, Dr. Sury stated that the Claimant could perform sedentary work. Labor market surveys showed appropriate jobs from mid-1994 until the Claimant underwent surgery on July 10, 1996.

The Employer also argues that Moore was again capable of working from May 1998 to the present and continuing.

Claimant's counsel states that his client underwent surgery in late 1987 and had 2 procedures in May 1988. A fusion was performed at a subsequent date.

Counsel reports that

> As of March 12, 1988, Claimant went back out on temporary total disability and remained in that status through July 13, 1994.
>
> From July 13, 1994 through July 19, 1996, the Carrier, without justification or explanation, reduced her benefits to temporary partial and paid her $14.00 per period for that length of time. In fact, Claimant's condition was such that it was the same on July 14, 1994 as it was in 1993, 1992, and going on back to March 1988. Her condition never changed from that period of time through the entire period that she was paid temporary partial disability benefits and beyond. In fact no doctor during that period of time released her to return to work and she was physically unable to do so under any circumstances during that period.

Moore's counsel states that

> Dr. Hogshead examined Claimant shortly before the hearing at the request of Carrier and opined originally that from an orthopedic stand point Claimant possibly could do secretarial work, but that she had decompensated to the point where her chronic pain syndrome would preclude her from being able to work at all.

Counsel states that following the fusion, Moore wore a full body brace for a year and subsequently had a hernia which required repair. It is argued that the Claimant continues

> to remain in the same physical condition she was in before the repair and at no time in this record is there any indication that a physician released her to return to any kind of duty, sedentary, light, partial or full. She continues to remain, based on the testimony and evidence in this record, temporarily and totally disabled and she should be compensated therefor.

Counsel notes that the Employer states that Moore could perform sedentary work except for her psychological problems. The Claimant

> testified that she was handling these other stressors, and would have been able to continue to do so, had it not been for the serious, chronic back pain. There is no competent, substantial evidence to the contrary.

The Claimant was paid temporary total disability from October 15 to October 19, 1987, from November 12, 1987 to March 12, 1988, and from March 24, 1988 to July 13, 1994. Temporary partial disability was paid from July 14, 1994 to July 9, 1996 at a rate of $14.72 per week. Temporary Total Disability was paid from July 10, 1996 to May 26, 1998. [EX 11].

Dr. Arce performed a laminectomy of L4-5 in November 1987. Similar procedures were performed at that level on two occasions in May 1988. [EX 14].

In January 1991, Moore was evaluated at the request of Dr. Godboldt. It was concluded that she was mildly depressed and experienced significant pain. A pain management program was recommended. [EX 20]. In July 1991, the Pain Management Center advised Dr. Godboldt that since January she had become more depressed and more somatically focused. [EX 19].

In early May 1992, Dr. Godboldt stated that the Claimant

> has been under therapy at the Clinic for Pain Management at University Medical Center regarding a complaint of failed back syndrome. Multiple interventions have been tried in this case with little prolonged response.
>
> She continues to be significantly impaired relative to the above noted diagnoses. She apparently experiences ongoing discomfort and is unable to perform

> strenuous domestic activity without significant exacerbations of her pain complaints.
>
> It is the opinion of this observer that with respect to Clinic for Pain Management interventions that this patient has in fact reached maximum medical improvement. [EX 19].

In mid-May 1992, Moore underwent an assessment of her physical/functional capabilities. It was reported that there was symptom magnification.

> Ms. Moore is unrestricted in sitting, as she sat for one hour and 18 minutes when performing the intake interview. She is restricted to 10 minutes of stationary standing, walking less than 1/4 mile, and climbing 40 stairs at one time, due to complaints of increasing right leg and low back pain. She is restricted to occasional static trunk bending, and overhead reaching due to complaints of increasing low back pain, and is restricted to performing repetitive one half squats vs. full squats secondary to patient intolerance. Ms. Moore is unable to stoop due to complaints of increasing low back pain.

It was concluded that she could perform sedentary work for 4 hours a day for 5 days each week. [EX 21].

In August 1993, Intracorp began a vocational assessment. Attempts to contact the Claimant were unsuccessful. In January 1994, Intracorp identified potential jobs that included customer service and a cashier. The surveys continued on a frequent basis through June 1994. It was reported that many of the potential employers stated that they would interview Moore if she applied. [EX 22].

Dr. Sury examined the Claimant in August 1994. Moore complained of

> lower back pain radiating down her right leg to the foot. She also complains of numbness in the right lower extremity. Ms. Moore states that she is unable to sit or stand for more than 10—15 minutes at a time. Coughing, sneezing, and straining on bowel movements aggravate her pain. She had seen Dr. Nguyen in June 1994 and he had advised an MRI. Following examination, Dr. Sury stated that

> I am an agreement with Dr. Arce that Ms. Moore reached Maximum Medical Improvement on 01/22/90 with a 20% permanent impairment of the whole person based upon the AMA Guidelines. Ms. Moore can continue her job search with the sedentary type work restrictions, with ten pounds maximum lifting, based on the work Capacity Evaluation Report dated 05/14/92. [EX 23].

Dr. Arce saw Moore on numerous occasions through 1992. In March 1993, she stated that she remained severely affected by back pain. The physician indicated that if the problem could not be managed with medication, the alternative was a lumbar fusion. In November 1993, Dr. Arce had a discussion with the Claimant's spouse who reported that she remained disabled by pain and was unable to do any type of significant physical activity.

On July 22, 1994, it was reported to Dr. Arce that

> At the beginning of June, after sitting for about four or five hours, Mrs. Moore noticed increased low back pain and right leg pain, and also increased feeling of numbness in her right leg from the knee down involving the entire leg. She has also noticed on and off discomfort in her left leg.

Following examination, the impression was chronic low back pain with exacerbation. The Claimant was to see Dr. Sury regarding her pain syndrome. Dr. Arce suggested a fusion and wrote a total disability slip through her appointment date of October 7, 1994. On October 7, the slip was renewed through November 7, 1994. [EX 14, pp 60-62].

The impression in early December 1994 was failed back surgery syndrome and Dr. Arce suggested a posterolateral fusion. In late May 1995, the physician stated that

> I had a long discussion with Mr. and Mrs. Moore about her condition and options of treatment. They would like to go ahead with the fusion and they understand the limitations of such treatment in her case. However, they have had problems with her workman′s compensation approving such a procedure. They would like to use Champus in order to proceed with this. They will let me know what type of arrangements can be made and once approval for this surgery has been obtained, plans are to proceed with a lumbar fusion with instrumentation from L4 to S1. [EX 14, p.67].

On August 23, 1995, Dr. Arce stated that Moore was to be hospitalized for a spinal fusion. [EX 14].

Dr. Scharf, an orthopedic surgeon, examined the Claimant on August 25, 1995 at the request of the carrier. The physician stated that

> I feel that Ms. Moore has segmental spinal instability and has three level degenerative disc disease. She will probably need a three level fusion if surgery is performed. Due to the extensive nature of the surgery, I would recommend combining the anterior and posterior fusion. Her overall prognosis is fair at best. She would gain significant improvement. [EX 24].

Dr. Arce referred Moore to Dr. Fessler who conducted an examination in June 1996. Dr. Fessler recommended a posterior L4 to S1 fusion with a subsequent anterior fusion. Such procedures were performed on July 10 and on July 17, 1996. In August 1996, Dr. Fessler prescribed a back brace, and in April 1997 such use was discontinued. [EX 25].

Extent of disability from July 14, 1994 to July 9, 1996

EX 11 reflects that permanent partial disability was paid during the above period. The contentions for this period have been previously mentioned.

Moore underwent a work capacity assessment in May 1992 and it was concluded that she could perform sedentary work for 4 hours every day. [EX 21].

At the request of the carrier, Dr. Sury examined Moore in August 1994 and concluded that she could perform sedentary work. [EX 23].

Moore did not cooperate with Intracorp but that firm did identify employers offering sedentary work in 1993 and in 1994. [EX 22].

However, in June 1994, Moore saw Dr. Nguyen and reported an increase in low back pain. In July, Dr. Arce suggested a fusion and provided total disability slips that continued into November 1994. From late 1994 through 1995 and into 1996, Dr. Arce

discussed a fusion which had been hindered by medical coverage concerns.

In August 1995, Dr. Scharf examined Moore at the request of the carrier. The physician recommended a spinal fusion. [EX 24].

In January 1996, Dr. Arce stated that

> Mrs. Moore is under my care for treatment of her low back pain. She is scheduled to undergo an evaluation by Dr. Richard Fessler for an anterior fusion at the L4-5 level. This is a specialized procedure, and because of the continued symptoms affecting Mrs. Moore I do not think it is in her best interest for her to go through a deposition at the present time considering her overall condition. [EX 14, p.73].

In March 1996, Dr. Arce stated that multiple treatments had failed to help Moore and that she was to be seen by Dr. Fessler.

Dr. Fessler examined the Claimant on June 18, 1996 and concurred in a diagnosis of L4-5 instability. Two fusions were performed in July 1996.

In late August 1996, Dr. Fessler stated that

> Based on my examination of Ms. Moore prior to her surgery and my evaluation of her level of pain prior to surgery, and my evaluation of her radiologic studies, I feel very unlikely that Ms. Moore could have engaged in any significant employment requiring prolonged sitting, walking, bending or physical labor prior to her recent surgery. [EX 25].

Dr. Sury felt that Moore could be employed full time in a sedentary job and the conclusion on the work capacities assessment was that Moore could work 20 hours per week.

Apparently, Dr. Arce was never contacted regarding the Claimant’s ability to work between July 1994 and July 1996. In view of complaints that began in June 1994, Dr. Arce placed the Claimant on totally disability into November 1994 and subsequent clinical notes repeatedly speak of the necessity of a spinal fusion.

Dr. Scharf, a non-treating physician, concurred in this assessment in mid 1995. Moreover, Dr. Fessler performed two procedures shortly after the initial examination.

I find it clear that Dr. Arce would not have approved any type of work during the period in issue as demonstrated by his placing her on total disability during late 1994. Therefore, Moore is entitled to temporary total disability during this time.

Extent of disability from May 27, 1998 to the present and continuing

A form Ls-208, dated in November 1998, states that temporary total disability was paid from July 10, 1996 to May 26, 1998. No compensation has been paid since May 1998. [EX 11] [See EX 32, p.23] [Tr 6].

Dr. Fessler continued to treat the Claimant after the surgery in 1996. Moore was provided with a back brace until April 1997. At that time, the physician stated that the anterior fusion was sub optimal in position. (Information in the file indicates that Moore underwent an incisional hernia repair in June 1997).

In May 1999, Dr. Fessler reported that

> She has done well postoperatively, but has had a great deal of emotional difficulties. Recently she lost her mother and another close relative. Although her husband is supportive she is having a great deal of difficulty coping.
>
> Today in clinic she has no back pain. Her incision is well healed. She has no abdominal pain or costvertebral angle tenderness. Her examination is entirely benign with full strength in both lower extremities, normal sensory examination, and normal gait. The films today reveal bone dowel halo phenomenon to have resolved suguesting good incorporation of the bone graft. There is no evidence of screw breakage or back out suggesting a solid fusion. The intertransverse bone fusion appears to have matured nicely.
>
> Our impression is that the patient is doing well status post posterior segmental instrumentation and anterior interbody lumbar fusion. [EX 25].

In August 1996, Dr. Arce stated that Dr. Fessler had performed an endoscopic fusion. In October 1999 Dr. Arce stated that Moore was doing well and was last seen in 1996. Impressions were

> STATUS POST ANTERIOR AND POSTERIOR LUMBAR FUSION, WITH SATISFACTORY RECOVERY.
> CHRONIC LOW BACK PAIN. [EX 14].

In October 1996, Moore was evaluated by Dr. Moreland, a psychologist. Impressions were

> Dysthymic Disorder Secondary To Chronic LBP
> R/O Pain Disorder Associated With Both Psychological And Physical Factors
> Psychosocial Stressers: surgery, perceived w/c harassment, relationship with oldest daughter

Dr. Moreland stated that

> Compared to other chronic pain patients, she engages in more catastrophizing. She tends to expect many different negative consequences when her pain increases, and she has few coping skills with which to handle pain exacerbations. He recommended psychological treatment, and referral to a psychiatrist for medication management. [EX 26].

Moore was hospitalized in University Medical Center from February 27 to March 2, 1997. The initial impression was suicidal ideations with pain. The diagnosis was depression. [EX 27].

Dr. Herbly, a psychiatrist, began treating the Claimant in March 1997. In September 1997, it was reported that the Claimant was dealing with the illnesses of 2 family members. In January, it was reported that there were numerous family stressors.

In July 1999, it was reported that

> HISTORY: no change in symptoms, continues to be quite depressed, stress in relationship with husband, two more deaths, pain is persistent and is a significant continuous stress. Response to current dose of Prozac has been partial.

Dr. Herbly stated that

> Symptoms of depression include persistent sadness, anhedonia, social isolation, interrupted sleep, decreased energy, weight loss, suicide ideas. The depression is persistent and daily. The physician advised a referral for psychotherapy. [EX 28].

An unsigned May 1999 report from Shands Clinic states the Claimant had no back pain and was considered to be doing well. Moore reported emotional difficulties due to family problems. [EX 29].

Dr. Guiot reported in May 2000 that

> Ms. Moore was last seen in this clinic one year ago. She was doing quite well at that time and continued to do so until January 2000. She began taking a course in acting. This was quite a physical class and she began experiencing both back and right lower extremity pain in February 2000. The back pain has not worsened. It has essentially remained status quo.
>
> Unfortunately, the right lower extremity pain has gotten consistently worse. It originates in the right hip region and radiates along the lateral aspect of the right thigh. It swings anteriorly at the level of the knee and descends further along the leg along the anterior border. There is further radiation along the dorsum of the right foot. There is occasionally numbness in the toes of the right foot. There is a generalized sense of weakness in the entire right lower extremity. The left lower extremity remains asymptomatic. Bowel or bladder function have remained unaffected.
>
> The pain is made worse with prolonged sitting, standing or activity. It is relieved with rest. There has not been any form of conservative management directed at these symptoms. There has been no imaging studies.
>
> The physician recommended diagnostic testing. [EX 29].

During a deposition in April 2001, the Claimant testified that when the back brace was removed in April 1997 physicians noticed a bulge in one of the incisions. A physician related the hernia to prior surgery, and the hernia was repaired.

Moore acknowledged an attempt at suicide in February 1997. She reported that in 2000 she went to 3 acting classes but dropped out due to the long drive and the physical nature of the activities. She conceded that she had not looked for work since September 1997 and stated that she was physically unable to work. [EX 32, p. 62].

At the request of the Employer, the Claimant was examined by Dr. Hogshead in early May 2001. The Claimant reported that

> she has pain on a daily basis that is particularly confined to the buttocks and posterior aspect of both legs. She complains of pain more in the right leg than the left. The pain tends to travel down the center of the leg and reaches all the way to the toes. The pain is aggravated by activity and generally relieved by being completely still. She also gets relief by taking medication.
>
> IMPRESSIONS were
>
> 1. Degenerative lumbar disc disease--multiple surgical procedures with an apparent solid spinal fusion L4 to the sacrum.
>
> 2. Chronic pain and disability syndrome (see discussion).
>
> 3. Severe deconditioning.
>
> 4. History of depression requiring institutionalization with continuing evidence of depression.
>
> 5. Osteoarthritis right hip.
>
> Dr. Hogshead stated that
>
> In answer to the questions posed by attorney Mesnard, Ms. Moore is unable to work. She will not be able to return to work under any foreseeable circumstances despite accommodation and restrictions. The history given is that her problems began following a 1987 injury. The temporal relationship of the development of that occurrence is somewhat vague. However, at this time, 14 years later and 6 operations later, we are unable to effectively challenge her assertion of that relationship. Ms. Moore did mention her acting class of January 2000, but did not mention incurring an

injury. Lacking further details, it would be the opinion of this examiner that the acting class was not a significant factor.

In late May 2001, the physician reported that

> Additional material in the form of surveillance video tapes has been received. A telephone conference with Mr. Mesnard (employer's counsel) was held as a clarification of the opinions expressed above. It the opinion of this examiner that Ms. Moore's primary disabling entity is the chronic pain syndrome. This is a problem which in itself carries no specific impairment rating. It is essentially a psychological problem.
>
> Considering ONLY the orthopaedic or musculoskeletal elements, Ms. Moore would be capable of performing a sedentary job, given the opportunity to become conditioned. [EX 33].

In June 2001, Dr. Hogshead added an addendum. The physician reported that

1. A suitable conditioning time to allow Ms. Moore to reenter the work force would be one month at a part time level. Further type of conditioning program would not be required.

2. The surveillance tape of Ms. Moore dated June 2001 is not persuasive. It does present an identifiable image of Ms. Moore. Pain behavior is not evident. If there is an established factual basis for claiming that Ms. Moore is indeed working in the Rosebuilt Office that would constitute substantial evidence that she is capable of employment.

3. Ms. Moore is physically capable of performing the tasks at least of ordinary light housekeeping.

4. It is my opinion that the hernia repair at Shands Hospital in June 1997 was in fact necessitated by the earlier laparoscopic procedure. The laparoscopic procedure in turn was necessitated by the 1987 injury.

5. I was previously informed of the traumatic spine injury in “1997". However, I was unaware that the treatment entailed surgery. Nevertheless, I am unable to separate a causal relationship, i.e. 1979 vs. 1987. There simply isn′t sufficient evidence to provide further indications of a causal relationship.

6. According to the history provided by Ms. Moore (and we have no conflicting evidence), the 1979 injury was the initiation of her spine problems. The passage of subsequent years and the subsequent operative procedures have obscured the evidence of the original injury. If she was originally accepted as a Workers’ Compensation injury in 1979, then so be it.

7. Again, there is not sufficient evidence to provide a clear, causal relationship between the 1979 and 1987 injuries. This examiner is unable to determine whether she would have been able to return to the job following the 1987 injury if she had not had the 1979. [EX 45].

Dr. Miller, a psychiatrist, examined Moore in May 2001. (She has been seen previously in February 1997). She currently reported that she was still depressed, had trouble walking due to pain, and at times thought her life was over. Mental status examination revealed a blank affect. She was depressed and wept frequently.

Dr. Miller reviewed numerous medical records and stated in a letter to Employer’s counsel that

In response to your specific questions:

1. The patient, in my opinion suffers a) Chronic Dysthymic Disorder; b) Major Depression by history; and c) Compulsive Personality Features.

2. In both the 1997 and the 2001 interview, Ms. Moore reported to me the onset of pain associated with work events occurring to her in 1987. Assuming a work-related event did occur at that time, it is my opinion that continuum of pain in association with emotional distress were established at that point and any preexisting problem was added to

(aggravated) rather than caused by the injury per se.

3. Ms. Moore, in my opinion, does not need restrictions from a psychiatric standpoint in order to work. I think the greater question is whether or not she can work. I have discussed with her my concern that she may need further medical appraisal regarding the need for estrogen replacement and thyroid assessment. A correction of these potential problems may enhance her return to the work force.

Comment: It is clear that there have been a lot of things going on in Ms. Moore's life. She has suffered many traumas through the years, both emotional and physical, and what we are seeing in her adaptation today is a product or a summation of all of these things together. I think her pain is real, not feigned. The Mensana Pain Clinic Test results are in conformity with this position. I think that she needs to have this lawsuit concluded and get on with her life to whatever manner and degree she is capable. I do not see her as a basket case and I have told her this, that she needs to bring all this to a conclusion and get on with her life. Medication adjustment and assessment regarding estrogen and thyroid needs are about as much as she needs, in my opinion. I do not think that further psychiatric care will assist at this point. [EX 31].

Melinda Hardie, a rehabilitation service provider, reviewed records, interviewed the Claimant, and performed a labor market survey in June 2001. Dr. Arce did not respond and the survey was based on Dr. Hogshead's opinion regarding sedentary work.

Ms. Hardie identified available jobs, in telemarketing, as an office assistant or receptionist, as a front desk clerk, and as a collection agent by telephone. Other potential jobs included unarmed security guard, inventory manager, and customer service representative. [EX 41].

At the hearing, the Claimant testified that she had not tried to work as

I don't sleep. I have to take medication to make me sleep. My back hurts all the time. There's no way that I could be a productive person for somebody and

work for them and say, I′m going to do this for you five days, four days or three days a week because I couldn′t. [Tr. 56].

Moore testified that she was hospitalized “for my nerves” in February 1997 but “I had not tried to kill myself.” [Tr. 78]. After review of a videotape Moore stated that on that day she went to visit Harriet Rose, owner of Rose Built, Inc. The Claimant denied ever receiving money from that firm. [Tr. 90].

Harriet Rose testified that she was an old friend of Moore and that she encouraged Moore to visit to get her out of the house. Moore visited frequently in the afternoons when Rose had idle time. Rose denied payments to Moore.

Joe Volante testified that he had videotaped the Claimant, and he described the activities. [See EX 43 and EX 44].

Melinda Hardie testified regarding her vocational report. She relied on reports of Drs. Hogshead and Sury as well as the 1992 FCE. Ms. Hardie noted that Dr. Miller reported that there were no psychological restrictions to work. Ms. Hardie testified that eleven of the employers listed in her report were hiring at the time of the report. [Tr. 135].

Hardie stated that while Dr. Hogshead indicated that the primary disabling entity was chronic pain syndrome, Dr. Miller had stated that there was no psychological impairment. Therefore, Hardie concluded that Moore could perform sedentary work. [Tr. 142].

Discussion

Dr. Arce was the primary treating physician until the surgery in 1996 and there is some indication that he has returned to being the primary treating physician. Dr. Fessler provided primary care from 1996 through 1999. Neither of these physicians has reviewed potential job descriptions or responded to such a request.

Ms. Hardie has based her vocational survey on reports of the 1992 FCE [EX 21], reports from Dr. Sury in 1994, and recent reports from Drs. Miller and Hogshead. It must be pointed out that the 1992 and 1994 reports predated the spinal fusions in 1996 and, therefore, have little credibility at this time.

Ms. Hardie’s dilemma in understanding the opinions of Drs. Miller and Hogshead is well taken. In addition, while the

Claimant has significant family psychological stressors the major diagnosis is chronic pain syndrome.

Dr. Miller stated that Moore's pain was "real, not feigned." Dr. Hogshead has indicated that Moore could perform sedentary work if she went through a conditioning program.

The undersigned does not see that Moore has even worked for Rose Built, Inc. The Claimant reports that she is relatively housebound due to chronic back pain. In view of five lumbar surgeries, including an anterior fusion, it is held the Claimant is credible and can not perform sedentary work on even a part time basis.

Order

1. The Employer is to pay Claimant temporary total disability from July 14, 1994 through July 9, 1996, and from May 27, 1998 to the present and continuing.

2. Prior awards of temporary total disability remain in effect.

3. The Employer shall provide treatment for lumbar impairment and for an incisional hernia pursuant to Section 7 of the Act.

4. The Employer shall receive credit for all compensation that has been paid.

5. Interest at the rate specified in 28 U.S.C. §1961 in effect when this Decision and Order is filed with the office of the District Director shall be paid on all accrued benefits computed from the date each payment was originally due to be paid. See Grant v. Portland Stevedoring Co., 16 BRBS 267 (1984).

6. All computations are subject to verification by the District Director.

7. The Claimant's attorney shall within twenty (20) days of receipt of this order, submit a fully supported fee application, a copy of which shall be sent to opposing counsel, who shall then have ten (10) days to respond with objections thereto.

8. No penalty shall be assessed against the Employer until ten days after notice of the amount to be paid.

A

RICHARD K. MALAMPHY
Administrative Law Judge

RKM/ccb
Newport News, Virginia